



## WORKING CONNECTIONS CHILD CARE (WCCC)

**EMPLOYER VERIFICATION**

LOCAL OFFICE	DATE
TELEPHONE NUMBER	CASE NUMBER

Please use blue or black ink and print or type clearly.

**Section 1: To be filled out by the client/employee.**

I authorize my employer to release information to the Department of Social and Health Services.

EMPLOYEE/PARENT/APPLICANT SIGNATURE	DATE
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**Section 2: To be filled out by employer.**

NAME OF EMPLOYEE	NAME OF EMPLOYER
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EMPLOYER'S ADDRESS

DATE EMPLOYEE STARTED WORK	DATE JOB WILL END	HOURLY RATE OF PAY OR SALARY  AGRICULTURAL/FARM WORK RATE OF PAY (EXAMPLE: \$8/BIN, \$7/PER TREE, .25 CENTS/PER POUND, ETC.)
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Tips ☐ No ☐ Yes; if yes, how often and how much? \_\_\_\_\_

Commissions ☐ No ☐ Yes; if yes, how often and how much? \_\_\_\_\_

Bonuses ☐ No ☐ Yes; if yes, how often and how much? \_\_\_\_\_

Overtime ☐ No ☐ Yes; if yes, how often? \_\_\_\_\_

Pay frequency: ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Two times a month ☐ Monthly

Work Schedule (include exact times when possible):

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Average hours per week:

EMPLOYER/OWNER/PERSONNEL OFFICER'S SIGNATURE

EMPLOYER/OWNER/PERSONNEL OFFICER'S: PRINTED NAME

EMPLOYER/OWNER/PERSONNEL OFFICER: TELEPHONE NUMBER